# Measuring the Quality of Maryland HMOs and POS Plans:

# *2008/2009 State Employee Guide*

MHCC
MARYLAND
HEALTH CARE
COMMISSION

## *About the Maryland Health Care Commission*

The Maryland Health Care Commission (MHCC) is a public regulatory commission appointed by the Governor with the advice and consent of the Maryland Senate. A primary charge of the Commission is to evaluate and publish findings on the quality and performance of commercial health maintenance organizations (HMOs), nursing homes, hospitals, and ambulatory surgery facilities that operate in Maryland. MHCC produces an annual comparative report series on the quality of commercial HMOs, with the cooperation of the health plans and their members. Additionally, MHCC coordinates efforts with the Office of Personnel's Employee Benefits Division to provide this guide to State employees. These annual performance reports are the only source of objective, comprehensive, independently audited information on the quality of Maryland commercial HMOs. More information about MHCC and reports it produces is available at **http://mhcc.maryland.gov.**

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# *About This Guide*

The State of Maryland collects and assesses data on the performance of its managed care plans to promote quality of care and improve the value of health care services for Marylanders. *Measuring the Quality of Maryland HMOs and POS Plans: 2008/2009 State Employee Guide* provides validated results that compare the performance of the Maryland plans offered to State employees on measures important for ensuring high-quality care and services. The State provides this guide to help you choose a health plan that works best for you. Use it in combination with the cost and benefit information available in the *2008 State of Maryland Summary of Health Benefits* booklet supplied by the Office of Personnel's Employee Benefit Division.

## THIS GUIDE INCLUDES

- Performance ratings on a range of health care measures, including member satisfaction, preventive care, children's health, chronic care, diabetes care, and behavioral health care, for each of the managed health plans offered to State employees.
- Comparisons of the statewide averages with regional and national averages. These comparisons show whether Maryland quality of care is similar to or different from that in surrounding states and in the nation as a whole.
- A new source of information comparing plan quality. This is the first year that *eValue8™** results are included as supplemental information to compare the quality of HMOs. *eValue8* is a health plan evaluation tool that measures both quality of care and cost-effectiveness. This information can more effectively support the complex information needs of State employees in making value-driven health care decisions.

## OTHER IMPORTANT CONTENT

This year's guide takes a closer look at the issue of health care disparities. Studies have identified differences in health care provided to populations based on race, ethnicity, and income level. Disparities in health care delivery result in lower quality of care. This guide:

- Looks at areas in which health care disparities exist**
- Highlights Maryland health plans' initiatives to improve care to different populations***
- Gives examples of federal and state actions to measure and reduce disparities in health outcomes

*_eValue8_ is a copyright of the National Business Coalition on Health.

**The performance ratings included in this guide do not assess health care differences based on race or other factors because health plans have limited information about members' race, ethnicity, and income.

***Each initiative is an example of how the health plan attempts to reduce disparities in care provided to its members. It does not represent an endorsement of the plan. Other health plans may have similar initiatives.

# *Measuring Quality*

## DATA SOURCES

The information presented in this guide comes from data that Maryland health plans gathered from their records and from their members, as required by the State. Data (rates) included here are not specific to Maryland State employees, but reflect the care provided to and the opinions of a sample of all members enrolled in the plans.

**Member Survey:** This symbol means that information was gathered from health plan members using a survey called the Consumer Assessment of Healthcare Providers and Systems, or CAHPS®.[a] This survey asks members about their experiences with their health plan. An independent company hired by the Commission conducted the survey using 1,100 randomly selected members from each plan.

**Health Plan Records:** This symbol means that information was gathered from health plan records using the Healthcare Effectiveness Data and Information Set, or HEDIS®,[b] a tool used to collect and report clinical health care information. All plans gathered information in the same way, and an independent company hired by the Commission checked their methods for accuracy.

The ratings for every plan include the combined data for HMO and POS members, except for Kaiser Permanente, whose ratings show HMO data only.

### New Data Source

**Health Plan Programs:** This symbol means that information was gathered from the health plan about its quality attainment programs, quality monitoring methods, and health system improvements.

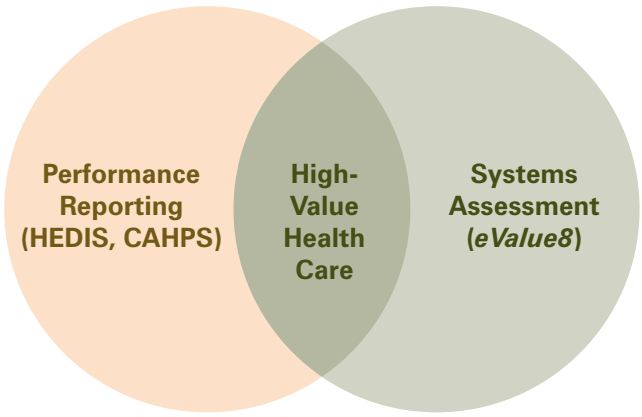
[a] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

[b] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

## MEASURING VALUE-BASED HEALTH CARE—A LOOK AT SYSTEMS

Value in health care is the intersection between quality of care and affordability. In a value-based health care system, health care buyers (e.g., employers) hold health care providers (e.g., health plans) accountable for both cost and quality of care. Value-focused initiatives emphasize collection of quality of care data, transparency of quality and cost information, and incentives to providers. As illustrated in the figure below, a high-value health plan achieves superior clinical results and member satisfaction (as measured by HEDIS and CAHPS) and optimal use of system-level resources (as assessed by *eValue8*). HEDIS, CAHPS, and *eValue8* are complementary tools for identifying and rewarding the best-performing health plans and enhancing the overall value for employers and consumers.

**Figure 1: Relationship Between Systems Assessment, Performance Reporting, and High-Value Health Care**




## LEADERS IN HEALTH CARE QUALITY ACCOUNTABILITY

In 2007, Maryland led efforts to expand health plan quality reporting to include preferred provider organizations (PPOs). Although enrollment in PPOs has surged to become the dominant choice of consumers, PPO members do not have objective sources of information, similar to this guide, to compare these plans. MHCC invited Maryland PPO plans to join in a voluntary effort to test the quality evaluation process for this plan type. Maryland insurers offering PPO health plans agreed to monitor the progress of the study. Aetna and CIGNA partnered with the MHCC, taking a vanguard position in assessing the challenges and successes of quality measurement by participating in all activities related to the quality measurement process. The MHCC commends these organizations for their willingness to be forerunners in the effort to apply accountability in health care. MHCC will continue to include all participating PPOs in its annual evaluation of health plan performance as part of the state's response to the changing information needs of consumers, employers, and policymakers. Aetna, CareFirst, CIGNA, and United will join the MHCC in partnership to collect and report PPO comparative data in 2008. MHCC will publish the information for the two PPOs offered to the State employees (CareFirst and United) in the spring 2009 edition of the employee guide.

# *Overview of Plans' Performance on HEDIS and CAHPS Measures*

The guide provides evaluations of the performance of five plans* available to Maryland State employees. The plans are evaluated on 24 measures that fall within six areas of care. The Maryland average for each performance measure is based on the results reported by the seven plans required to submit reports to MHCC.

Table 1 gives a snapshot of plans' high performance in 2007, showing the measures for which each plan received an above-average score compared with the Maryland average in 2007.

**Table 1: Summary of Above-Average Performance**

| Health Plan | Number of Scores Above Average | Measures with Above Average Scores |
|---|---|---|
| **HMO** | | |
| BlueChoice | 4 | Immunization for Children<br>Postpartum Care<br>Controlling High Blood Pressure<br>Cholesterol Control |
| Kaiser Permanente | 8 | Cost of Prescription Drugs<br>Breast Cancer Screening<br>Chlamydia Screening<br>Postpartum Care<br>Controlling High Blood Pressure<br>Eye Exams<br>Medical Attention for Kidney Disease (Diabetic Nephropathy)<br>Initiation of Alcohol and Other Drug Treatment |
| OCI | 3 | Well-Child Visits for Infants and Children<br>Well-Care Visits for Adolescents<br>Follow-Up Care for Children Prescribed ADHD Medication—Initiation |
| **POS Plan** | | |
| Aetna | 1 | Initiation of Alcohol and Other Drug Treatment |
| M.D. IPA | 7 | Colorectal Cancer Screening<br>Immunization for Children<br>Eye Exams<br>Well-Child Visits for Infants and Children<br>Disease Modifying Anti-Rheumatic Drug Therapy (DMARD) in Rheumatoid Arthritis<br>Antidepressant Medication Management<br>Follow-Up Care for Children Prescribed ADHD Medication—Initiation |

*Additional information about each plan is provided on page 22.*

# *Choosing Value-Based Health Care*

## eVALUE8 BEYOND THE NUMBERS

Quality measurement of health plans calls for dependable methods to fairly assess and compare how often members receive recommended care. Understanding health plan performance is incomplete, however, without looking beyond rates of care and into the processes health plans have in place to make services possible. Featured for the first time in this guide, results gathered using the *eValue8* tool provide employers, employees, and legislators with a measure of how well health plans manage the health of their member communities by implementing processes that activate high levels of quality care. *eValue8* provides an in-depth analysis of plan processes and performance in seven categories that evaluate the system as a whole. Results from five of these categories are presented in this guide.

- Consumer Engagement
- Preventive Care
- Disease Management
- Prescription Management
- Behavioral Health Care
- Plan Profile
- Provider Management

## ABOUT eVALUE8

The *eValue8* tool is a product of the National Business Coalition on Health, a national, non-profit, membership organization of nearly 70 employer-based health care coalitions, representing over 10,000 employers across the United States. The tool assesses health plans based on hundreds of established benchmarks in the seven evaluation categories listed above.

The Mid-Atlantic Business Group on Health, the local affiliate for Maryland employers, has invited several major health plans in the region to submit information on their plan management and quality programs using the *eValue8* tool. Aetna, BlueChoice, Kaiser Permanente, and Optimum Choice have completed the tool for several years to provide important details to stakeholders on their quality processes. In future editions of this guide, all plans meeting the requirements to report performance information to the State will have the same opportunity to provide this expanded, plan-defining information to Marylanders.

## eVALUE8 PLAN PERFORMANCE SUMMARY

These results are based on an assessment of Aetna, BlueChoice, Kaiser Permanente, and OCI's administrative processes and quality improvement programs. The charts on page 5 provide more information about plans' performance relative to each other and to national benchmarks.

- Kaiser Permanente scored highest in three of the five measurement categories, followed by Aetna, which had the highest score for the remaining two categories presented in this guide. These high rates form the regional benchmarks for inter-plan performance comparison and plans' internal evaluation for further program development.

- An assessment of methods to *engage consumers* in their health care showed wide variations in plan performance. Scores for this measure ranged from 18–54 percent. Implementation of member decision tools that aid in cost and quality determination will improve scores within this category. Examples include: detailed practitioner information, benefit designs that encourage use of hospitals that meet safety standards, and online ability to view claim status and progress toward deductible.

- Kaiser Permanente did better than other plans in monitoring the effectiveness of programs designed to address issues of overuse, underuse, and misuse of prescription drugs. Its score was 98 percent, while other plans' scores ranged from 42–54 percent. The score for this category emphasizes the plan's management of prescription drug use and efficiency. For example, plans that have high rates of generic drug use and have procedures for dose optimization (member takes fewer pills per day) will achieve higher scores in this category.

- Aetna performed best in managing its members' behavioral health care, with a score of 77 percent. Bluechoice, Kaiser Permanente, and OCI received similar scores: 65 percent, 64 percent, and 62 percent, respectively. Essential programs to score well within this category include those that focus on community collaboration, such as discussing use of common screening tools with other plans and plan support of practitioners.

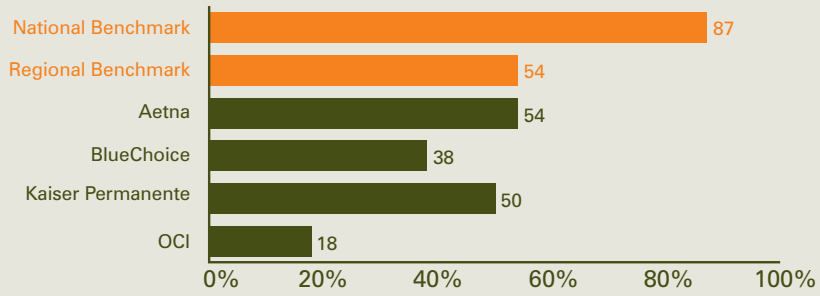
The charts on this page summarize how plans performed on five eValue8 measures. Bar graphs show plan scores for each area along with national and regional benchmarks. Scores are on a scale of 0–100 percent. Each benchmark, the highest score achieved for a measurement area, represents the comparative standard to judge plan results.

## Data Source: Health Plan Programs

### Consumer Engagement

Assesses how the plan provides members with tools and strategies to support members' management of their health benefits. Examples include Web-based practitioner directories, electronic personal health records, and cost estimation tools for medical services and prescription drugs.

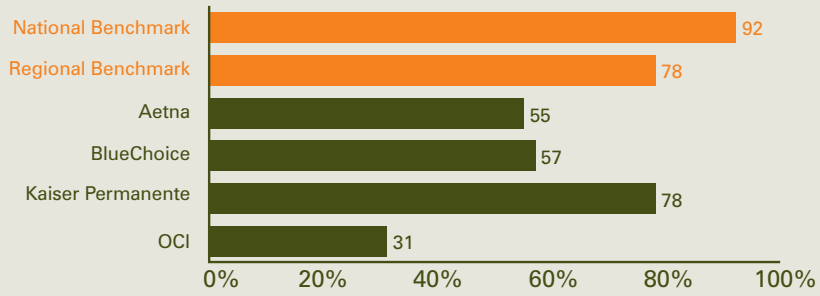
- National Benchmark = 87%
- Regional Benchmark = 54%




### Preventive Care

Assesses availability and types of programs offered by the plan to screen for cancer, promote health education, and support healthier birth outcomes. HEDIS rates are included in the overall score as a measure of the effectiveness of immunization and cancer screening programs.

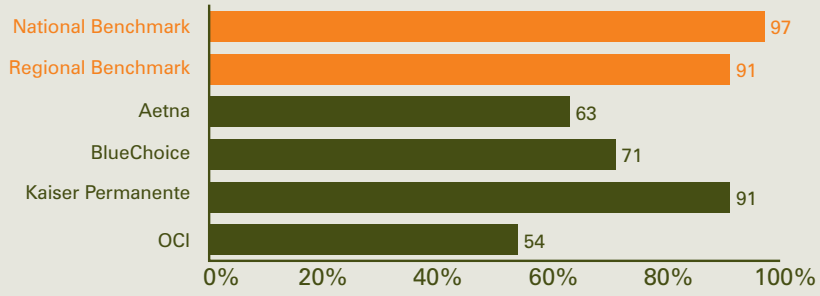
- National Benchmark = 92%
- Regional Benchmark = 78%




### Disease Management

Assesses the breadth of the plan's disease management programs, with specific emphasis on diabetes and coronary artery disease. To determine the effectiveness of member and practitioner support programs, HEDIS rates for the two disease conditions are used to measure program performance.

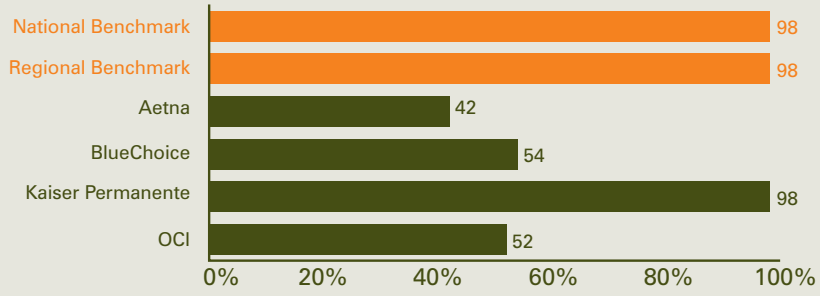
- National Benchmark = 97%
- Regional Benchmark = 91%




### Prescription Management

Assesses the plan's programs to manage and monitor issues of overuse, underuse, and misuse of prescription drugs. Examples include how plans monitor and take action on prescribing conflicts and manage the outpatient pharmacy network to ensure quality and safety.

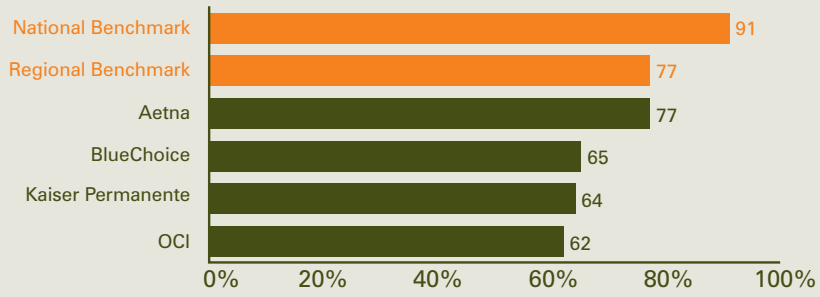
- National Benchmark = 98%
- Regional Benchmark = 98%

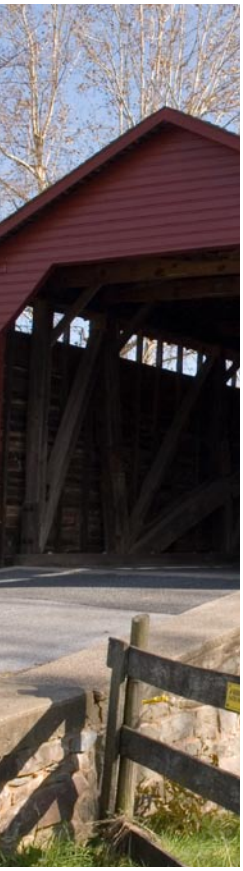



### Behavioral Health Care

Assesses plan's programs to manage depression, screen for alcohol overuse, and other points in the provision of behavioral health services. HEDIS rates are included in the overall score as a measure of the effectiveness of programs to manage alcohol and depression.

- National Benchmark = 91%
- Regional Benchmark = 77%





# *Member Satisfaction*

## ETHNIC/RACIAL DIFFERENCES IN SATISFACTION WITH HEALTH PLAN AND CARE

Surveys of health plan members show differences in the level of satisfaction of minorities and people who earn lower incomes regarding their health plan and health care. The National Research Corporation's 2001 Healthcare Market Guide Survey showed that nationally, Blacks and Asian Americans and Pacific Islanders gave lower ratings than did Whites when asked about their overall satisfaction with their health plan; Hispanics were more likely to intend to switch to a different plan than Whites were; and Asian Americans and Pacific Islanders and Hispanics gave lower ratings for customer service and access to care than did other members.

Surveys also show differences in how people of different racial and economic groups rate their satisfaction with the medical care they receive. For example, the Commonwealth Fund's 2006 Health Care Quality Survey shows that Whites (57 percent) and Blacks (56 percent) are more likely than Hispanics (46 percent) and Asian Americans (48 percent) to report getting timely care. Both Hispanics and Asian Americans are less likely to say that they received appointments on the same day they called their doctor, or the next day, and they are more likely to report that they had to wait six days or more to be seen. While 14 percent of Whites reported waiting six days or longer for medical appointments, 26 percent of Hispanics and 18 percent of Asian Americans reported similar waiting periods.

The 2006 CAHPS survey of Maryland health plan members produced findings consistent with these survey findings in several areas, particularly in lower satisfaction among Hispanics and Asian Americans as compared to Whites and Blacks. In five satisfaction measures (Getting Needed Care, Getting Care Quickly, Rating of Personal Doctor, Rating of Health Care, and Rating of Health Plan), Blacks expressed higher satisfaction than any other group. While the percentage of Whites who gave ratings of 8, 9, or 10 for these measures followed closely behind that of Blacks, a wider gap existed among the percentage of Hispanic and Asian Americans who gave these ratings, as compared to Whites and Blacks. For example, results for the Rating of Health Care measure show high satisfaction from 50 percent of Blacks and 48 percent of Whites with their health care, compared to only 33 percent of Hispanics and 30 percent of Asian Americans who gave ratings of 8, 9, or 10.

## ADDRESSING DISPARITIES IN CARE—KAISER PERMANENTE CULTURALLY AND LINGUISTICALLY APPROPRIATE CARE INITIATIVES

Kaiser Permanente actively collects demographic data from its members through a member survey and uses data in its electronic medical record system to identify health care disparities to work on eliminating them and best meet the diverse cultural needs of its member community.

Currently, Kaiser Permanente is engaged in a wide variety of programs to enhance the care experience for its members, with a strong focus toward wellness and reducing reliance on family members as interpreters. Programs include the following.

- Latino Centers of Excellence at seven medical centers throughout the Mid-Atlantic states, which streamline access of care for members and provide specific clinical programs focused on asthma to create improved outcomes for this population
- A Qualified Bilingual Staff training program for interpretation services
- Implementation of 14 Culturally and Linguistically Appropriate Services (CLAS) standards, as issued by the Department of Health and Human Services
- A Diversity Program with a formal infrastructure, staff, and resources to deliver initiatives focusing on culturally competent care

*These initiatives are examples of how Kaiser Permanente sought to address issues related to health care disparities in its program. The Commission takes no position on the claimed motivations, methodologies, or results of these quality initiatives.*

The charts on this page summarize how members rated their health care experiences, and how easy it is for them to get care. Bar graphs show plan scores and performance for each area. More stars mean better plan performance.

**Performance**

★★★ Above Average
★★ Average
★ Below Average

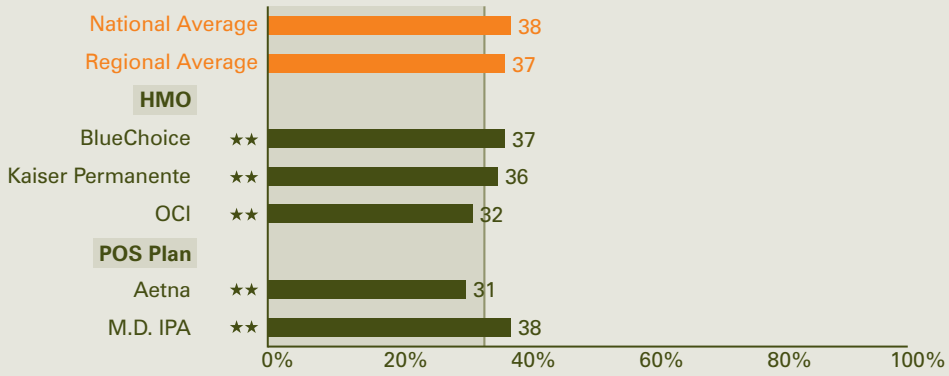
*Stars show "statistically significant" differences between each plan's score and the Maryland average. This means that scores varied by more than could be accounted for by chance.*

## Data Source: Member Survey

### Rating of Health Plan

The percentage of members who rated their health plan "9 or 10" on a scale of 0–10, with 10 being the "best health plan possible."

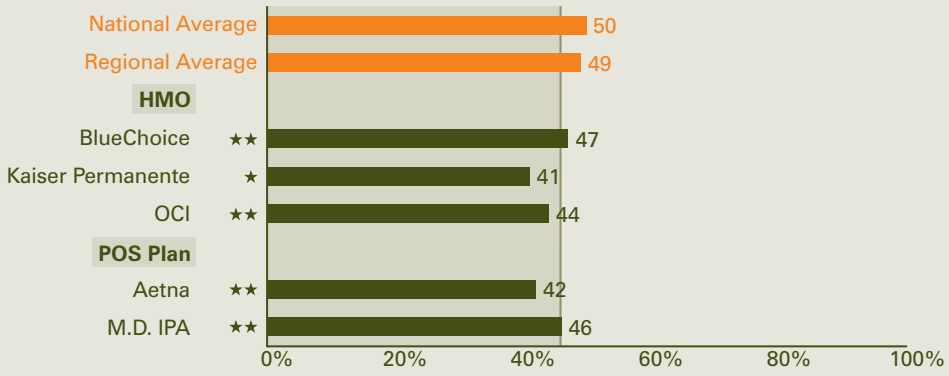
MD Plan Average = 34%
National Average = 38%
Regional Average = 37%




### Getting Needed Care

The percentage of members who said it was "always" easy getting appointments with specialists and getting needed care, tests, or treatment.

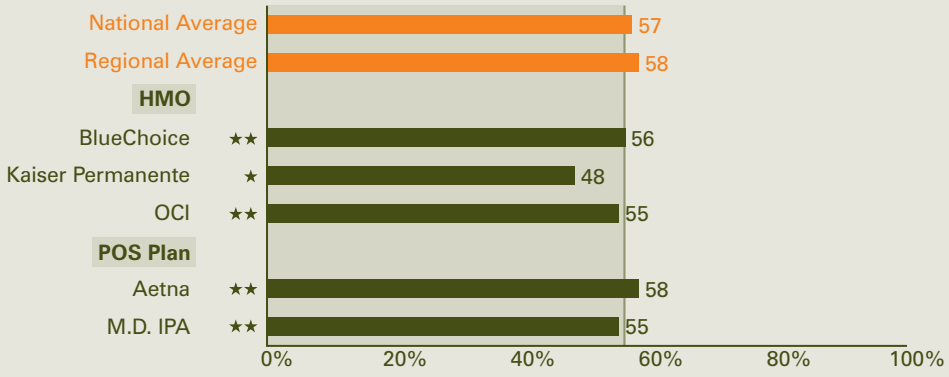
MD Plan Average = 46%
National Average = 50%
Regional Average = 49%




### Getting Care Quickly

The percentage of members who said they "always" got needed care when they wanted and got timely appointments for care at a doctor's office or clinic.

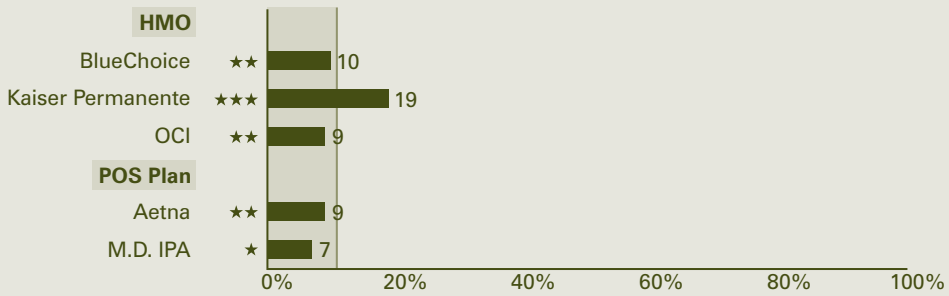
MD Plan Average = 56%
National Average = 57%
Regional Average = 58%




### Cost of Prescription Drugs

The percentage of members who said that the out-of-pocket payment for prescription drugs in their health plan was less than they expected.

MD Plan Average = 11%



# *Adults' Preventive Care*

## ETHNIC/RACIAL DIFFERENCES IN ADULTS' PREVENTIVE CARE

The health care paradigm emphasizes disease prevention and reduction in the effects of disease. For adults, this means undergoing screenings for life-threatening or chronic illnesses (such as cancer) and reducing or stopping dangerous, high-risk behaviors (such as smoking). Identifying where disparities exist in preventive care services will guide health plans and policymakers in targeting their actions to address the needs of underserved populations.

As noted on Medline Plus, prenatal care is more than just health care during pregnancy. Health care providers discuss many issues, such as nutrition and physical activity, what to expect during the birth process, and basic skills for caring for a newborn. A promising new direction has emerged with recent studies showing the racial prenatal care gap has shrunk. Differences persist in infant mortality rates, despite the increases in prenatal care. The Centers for Disease Control and Prevention (CDC) has set in motion strategies to focus on modifying the behaviors, lifestyles, and conditions that affect birth outcomes, such as smoking, substance abuse, poor nutrition, lack of prenatal care, and chronic illness. The Maryland Health Care Commission collects data about prenatal care on members enrolled in HMO/POS plans to gauge the proportion of pregnant women receiving care from a practitioner compared to those who did not initiate care. In 2006, on average, 92 percent of pregnant women enrolled in Maryland plans received prenatal care.

Cancer screenings occur less frequently in general and even less frequently for some populations, than recommended. Among the people who participated in The Commonwealth Fund's 2006 Health Care Quality Survey, only 39 percent of Hispanics—compared with more than 50 percent of Whites, Blacks, and Asian Americans—were screened for prostate cancer. Less pronounced differences were found among women who received mammograms with more than 70 percent of all White, Hispanic, and Asian American women identified as receiving a mammogram.

## ADDRESSING DISPARITIES IN CARE—AETNA BREAST HEALTH ETHNIC DISPARITY INITIATIVE

The Aetna Breast Health Ethnic Disparity Initiative Program and Research Study is a program that earned NCQA's CLAS Award for Innovation in Multi-Cultural Health Care. The goal of the program, initiated in 2003, is to increase the number of Black and Hispanic women receiving yearly breast cancer screening mammograms. A call from a nurse and a follow-up letter helps members locate a screening facility. The program has successfully identified and delivered this service to 8,500 women each quarter (34,000 women per year) since its inception. It is available to women enrolled in all Aetna medical products and in all regions of the country.

Through this program, Aetna has identified issues that reduce the likelihood of a member receiving a mammogram, such as the availability of mammography providers and claims payment policies related to scheduling a mammogram. Nurses and care management associates contact members to resolve barriers to mammography screening services. Recently, Aetna increased the number of full-time bilingual care management associates to better accommodate its Spanish-speaking members. At the end of 2007, Aetna plans to perform a study of the effectiveness of this program. Preliminary data show increased use of the screening mammography by 15 percentage points.

*This initiative is an example of how Aetna sought to address issues related to health care disparities in its program. The Commission takes no position on the claimed motivations, methodologies, or results of this quality initiative.*

The charts on this page summarize how well plans provided their adult members with important preventive care services. Bar graphs show plan scores and performance for each area. More stars mean better plan performance.

**Performance**

★★★ Above Average
★★ Average
★ Below Average

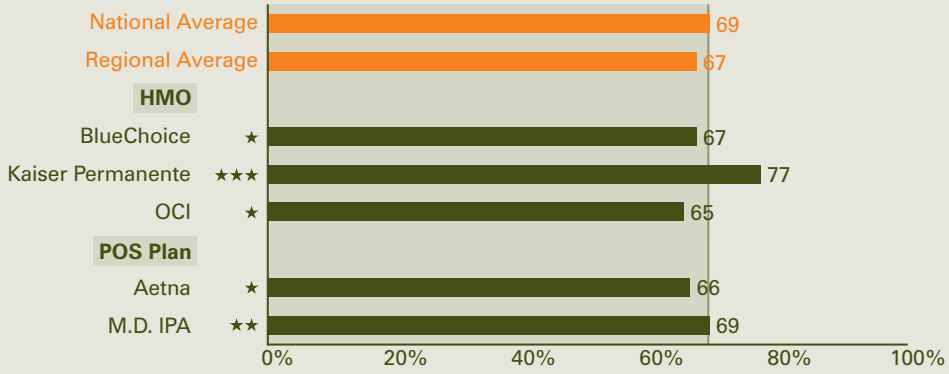
*Stars show "statistically significant" differences between each plan's score and the Maryland average. This means that scores varied by more than could be accounted for by chance.*

**Data Source: Health Plan Records**

## Breast Cancer Screening

The percentage of women ages 40–69 who had a mammogram in 2005 or 2006.

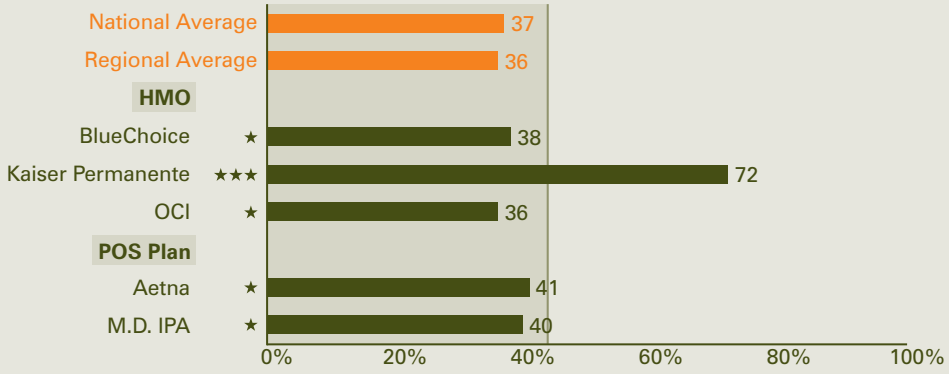
- MD Plan Average = 69%
- National Average = 69%
- Regional Average = 67%




## Chlamydia Screening

The percentage of women ages 16–25 who had a test in 2006 for chlamydia, a sexually transmitted bacterial infection.

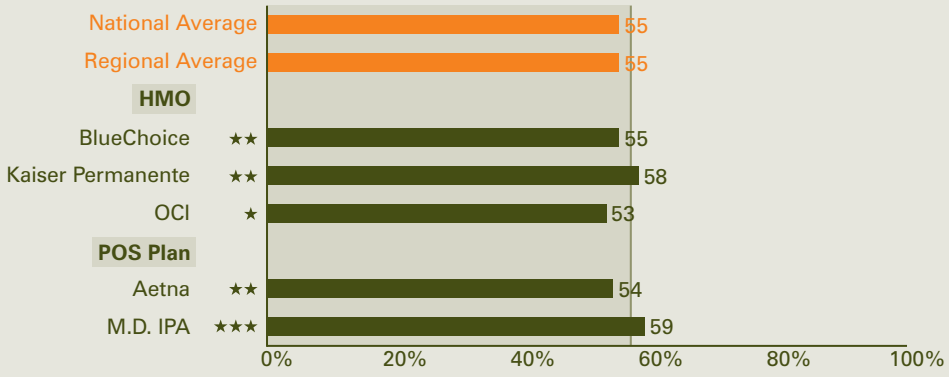
- MD Plan Average = 44%
- National Average = 37%
- Regional Average = 36%




## Colorectal Cancer Screening

The percentage of adults ages 50–80 who received a test that screens for colon cancer.

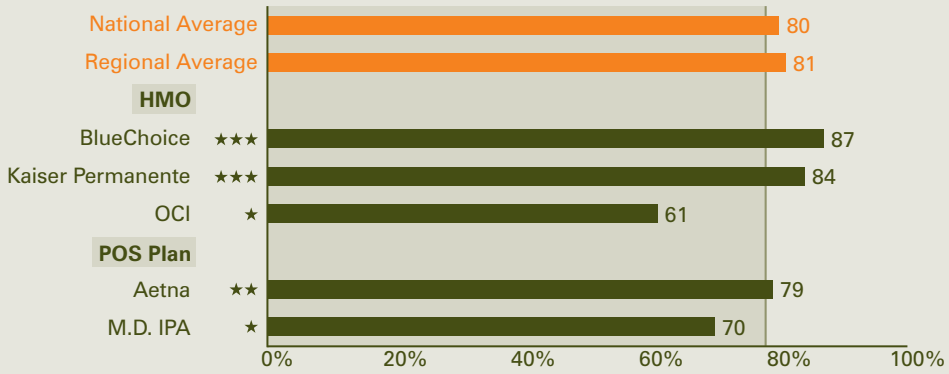
- MD Plan Average = 57%
- National Average = 55%
- Regional Average = 55%




## Check-Ups for New Moms (Postpartum Care)

The percentage of women who gave birth and had a postpartum visit on or between 21 and 56 days after delivery.

- MD Plan Average = 78%
- National Average = 80%
- Regional Average = 81%



# *Children's Health*

## ETHNIC/RACIAL DIFFERENCES IN CHILDREN'S HEALTH

Children make up slightly more than one quarter of Maryland's population of 5.6 million people. Racial minorities accounted for almost 42 percent of the children living in Maryland in 2006. The 2003 Maryland Asthma Surveillance Report reveals that one out of every 10 Maryland residents is directly affected by asthma, which is identified as the leading cause of school absence due to chronic disease. The CDC's Behavioral Risk Factor Surveillance System reports that about 150,000 Maryland children have been diagnosed with asthma, a prevalence rate parallel to the national rate. Maryland surveillance additionally reports asthma, a disease which can be controlled, as the cause of 39,019 emergency department visits, 8,000 hospitalizations, and 88 deaths in an average year.

According to the 2004 Maryland Asthma Plan, young adults, the elderly, women, Blacks, and individuals with lower incomes are disproportionately impacted by asthma, while young children with asthma have increased episodes of severe events. The 2005 Fact Sheet from the Agency for Healthcare Research and Quality (AHRQ) reports that Black children are one-third as likely as White children to use daily inhaled anti-inflammatory medications to help control their asthma. Hispanic children are two-thirds as likely as White children to use daily inhaled anti-inflammatory medications.

Further compounding the impact of asthma, a 2005 Environmental Protection Agency survey found that fewer than 30 percent of people with asthma take simple steps to reduce exposure to asthma triggers. Exposure to asthma triggers such as secondhand smoke, cockroaches, dust mites, mold, and ozone can cause asthma in young children or set off asthma attacks.

## ADDRESSING DISPARITIES IN CARE—UNITEDHEALTHCARE GENERATIONS OF WELLNESS℠—STEWARDS OF GOOD HEALTH INITIATIVE

UnitedHealthcare created Generations of Wellness℠ to better serve the health needs of Black families. This initiative was designed to help make Black members enrolled in UnitedHealthcare's various health plans, such as M.D. IPA and OCI, guardians of their own good health. By emphasizing awareness and education, and by promoting new attitudes toward healthy living, UnitedHealthcare has set a goal of bringing a greater level of parity to the quality of health care and health coverage for Blacks. Support is available through member education on topics that disproportionately affect Blacks, including asthma, breast cancer, prostate cancer and more. Beginning in 2008, UnitedHealthcare will launch a new series of educational tools that address the unique health care needs of children and young adults with asthma.

*Note: M.D. IPA and OCI are owned and operated by Mid-Atlantic Medical Services, LLL (MAMSI), a regional holding company and subsidiary of UnitedHealth Group, Inc.*

*This initiative is an example of how UnitedHealthcare sought to address issues related to health care disparities in its program. The Commission takes no position on the claimed motivations, methodologies, or results of this quality initiative.*

The charts on this page summarize how well plans provided children with important preventive care services. Bar graphs show plan scores and performance for each area. More stars mean better plan performance.

**Performance**

★★★ Above Average
★★ Average
★ Below Average

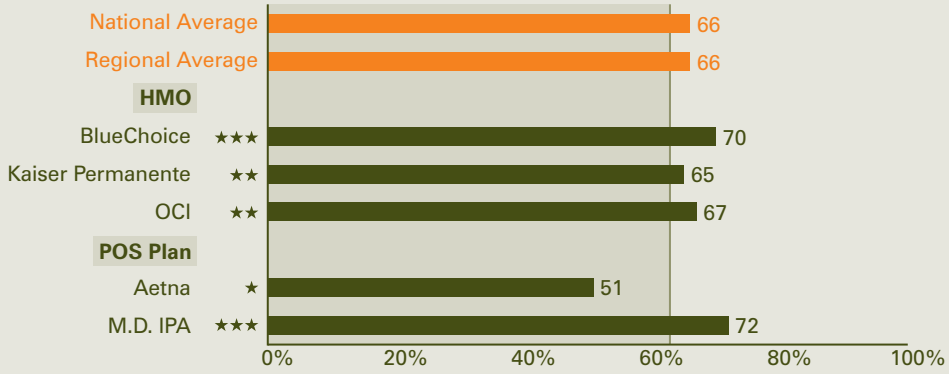
*Stars show "statistically significant" differences between each plan's score and the Maryland average. This means that scores varied by more than could be accounted for by chance.*

**Data Source: Health Plan Records**

## Immunization for Children

The percentage of children who received vaccines by age two for measles, mumps, and rubella (MMR); polio; influenza (flu) type B; hepatitis B; chicken pox (VZV); pneumonia; and diphtheria, tetanus, and pertussis (DTaP/DT).

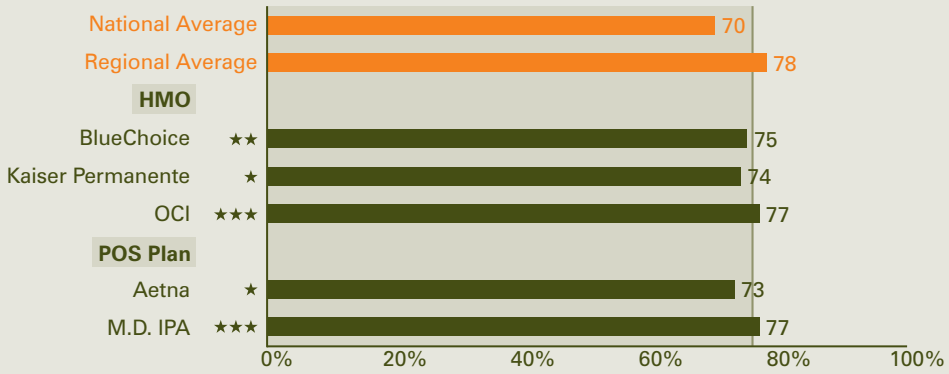
MD Plan Average = 63%
National Average = 66%
Regional Average = 66%




## Well-Child Visits for Infants and Children

The combined percentages of infants who had six or more visits by age 15 months, and children ages 3–6 years who had at least one visit to a primary care provider during 2006.

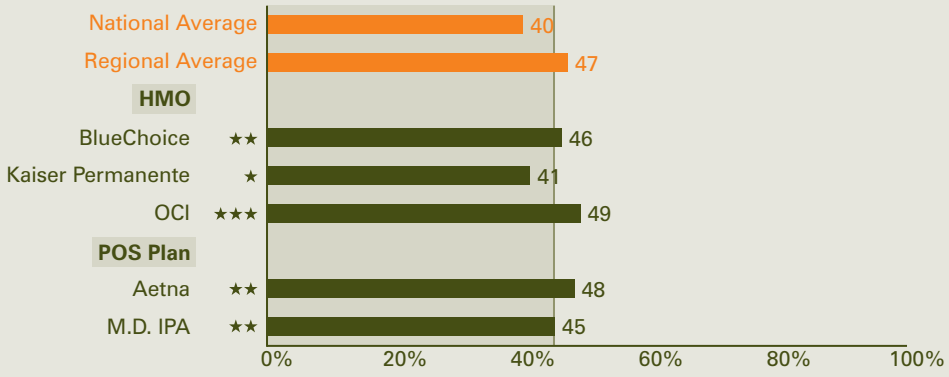
MD Plan Average = 76%
National Average = 70%
Regional Average = 78%




## Well-Care Visits for Adolescents

The percentage of adolescents ages 12–21 who had at least one visit to a primary care provider during 2006.

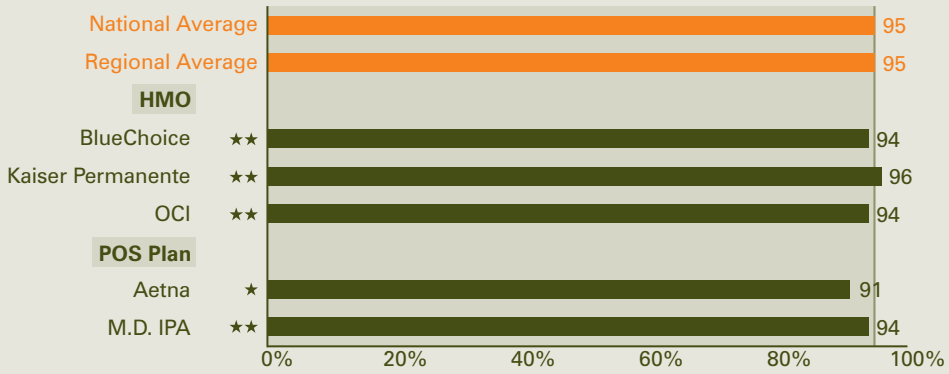
MD Plan Average = 45%
National Average = 40%
Regional Average = 47%




## Appropriate Medicine for Children With Asthma

The percentage of members ages 5–17 with persistent asthma who received inhaled asthma medicine (corticosteroids or one of four alternative therapies) in 2006.

MD Plan Average = 95%
National Average = 95%
Regional Average = 95%



# *Chronic Care*

## ETHNIC/RACIAL DIFFERENCES IN CHRONIC DISEASE CARE

Proper management of chronic health conditions, such as high blood pressure and heart disease, requires continuous access to high-quality care. According to the 2006 Health Care Quality Survey conducted by The Commonwealth Fund, Blacks have the highest rates of chronic conditions, including diabetes, high blood pressure, asthma, emphysema, and heart disease—yet Blacks and other minority groups experience poor management of their conditions. Proper care requires that patients receive advice about self-management strategies. For example, patients with chronic high blood pressure should be counseled about controlling their blood pressure through self-monitoring at home. Survey results suggest variations in who gets this professional medical advice: 54 percent of Asian Americans and 48 percent of Hispanics reported that they were not given a plan to manage their care at home, compared to 31 percent of Whites.

Lack of awareness of the risks posed by diabetes and high blood pressure hampers treatment and lifestyle changes needed to reduce the effects and progress of the diseases. A pilot study by the U.S. Office of Minority Health, aimed at standardizing screening forms, assessed both perceived and actual risk of developing diabetes and high blood pressure by selecting a random sample of screening forms completed primarily by Black participants. The study revealed that a significant proportion of the individuals who scored at high risk for either of these diseases were unaware of their risk for these conditions. This suggests the need to develop culturally relevant interventions, public health education, and policies that address the risk misperceptions. This is especially important, as the report noted that 44 percent of diabetes cases and 25 percent of high blood pressure cases in Blacks are not diagnosed. Conversely, results of a 2007 study published in Proceedings of the National Academy of Sciences show that undiagnosed diabetes in Black and Hispanic men is no more likely than for White men. This suggests that directed educational efforts may have achieved their intended goal of improving awareness.

According to the Maryland's Heart Disease and Stroke Prevention Program 2007 Fact Sheet, the percentage of Maryland residents told by a health care provider that they have high blood pressure was 26 percent in 2005. There was little difference between the genders or races in Maryland's general population. High blood pressure was the most commonly diagnosed condition in stroke patients in Maryland in 2005. Of those hospitalized with stroke, high blood pressure was more common in females than males, and more common in Black patients than in White patients.

## ADDRESSING DISPARITIES IN CARE—CAREFIRST BLUECHOICE'S CLOSING THE GAPS INITIATIVE

As part of a systematic approach to reduce health care disparities, BlueChoice's "Closing the Gaps" program addresses health disparities issues in a variety of formats, including programs that target communities and initiatives that target practitioners. BlueChoice recently launched a new initiative that provides education and training to practitioners.

BlueChoice partnered with the Manhattan Cross Cultural Group (MCCG) to offer Quality Interactions, an online cultural training course for physicians. Quality Interactions helps to improve skills and knowledge to strengthen communication with patients of different ethnic and racial backgrounds. It provides information on cross-cultural issues, conducting a culturally competent history and medical examination, effectively explaining a patient's diagnosis and management options, and negotiating a treatment plan that improves patient cooperation.

*This initiative is an example of how CareFirst BlueChoice sought to address issues related to health care disparities in its program. The Commission takes no position on the claimed motivations, methodologies, or results of this quality initiative.*

The charts on this page summarize how well plans provided their adult members with important health care services. Bar graphs show plan scores and performance for each area. More stars mean better plan performance.

**Performance**

★★★ Above Average
★★ Average
★ Below Average

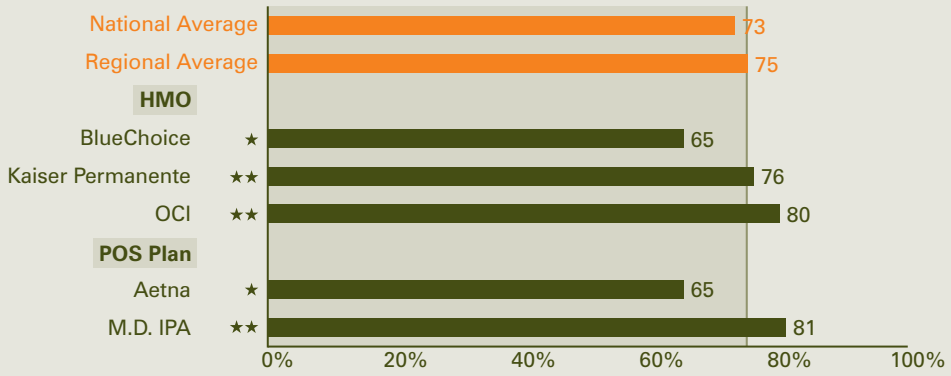
*Stars show "statistically significant" differences between each plan's score and the Maryland average. This means that scores varied by more than could be accounted for by chance.*

**Data Source: Health Plan Records**

## Persistence of Beta-Blocker Treatment After a Heart Attack

The percentage of members ages 35 and older who were hospitalized due to a heart attack and received a beta-blocker medication for six months after discharge.

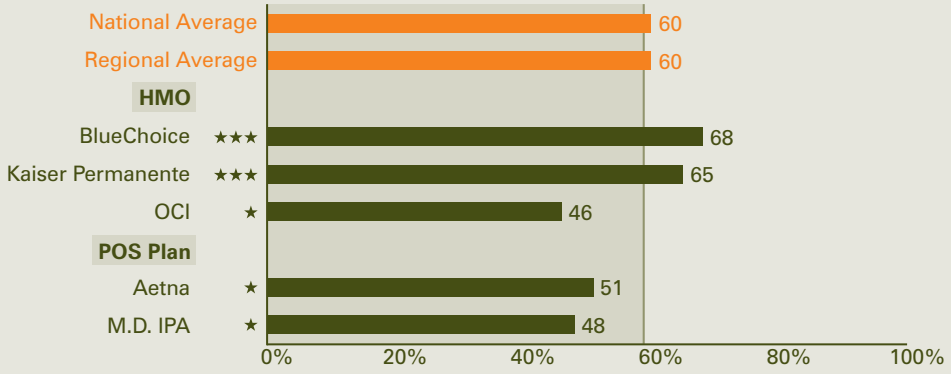
- MD Plan Average = 75%
- National Average = 73%
- Regional Average = 75%




## Controlling High Blood Pressure

The percentage of members ages 18–85 with high blood pressure, who had controlled levels of pressure (<140/90) during 2006.

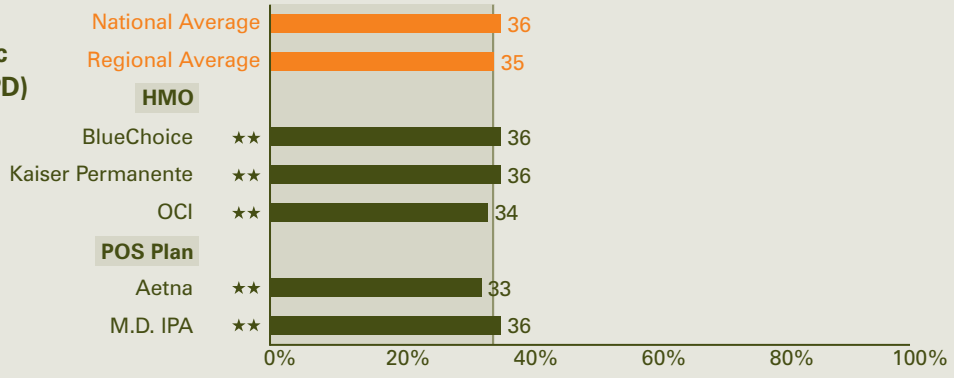
- MD Plan Average = 59%
- National Average = 60%
- Regional Average = 60%




## Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD)

The percentage of members ages 40 and older with newly diagnosed or newly active COPD who received appropriate testing, using spirometry, to confirm the diagnosis.

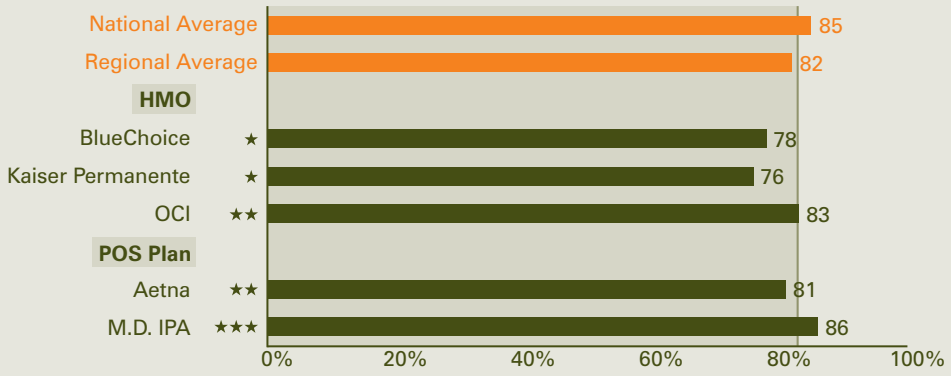
- MD Plan Average = 35%
- National Average = 36%
- Regional Average = 35%

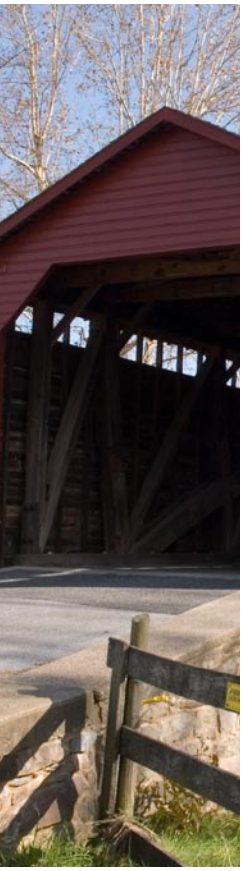



## Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy in Rheumatoid Arthritis

The percentage of members diagnosed with rheumatoid arthritis who were given at least one DMARD prescription in 2006.

- MD Plan Average = 83%
- National Average = 85%
- Regional Average = 82%





# *Diabetes Care*

## ETHNIC/RACIAL DIFFERENCES IN DIABETES CARE

Research shows that diabetes has significant effects on the health of Maryland residents and their use of services in Maryland. The Maryland Diabetes Prevention and Control Program Diabetes Fact Sheet states:

- In 2006, an estimated 334,000—or 7.9 percent—of Maryland adults had diagnosed diabetes
- Diabetes prevalence is higher among Blacks than among Whites
- In 2005, there were 9,344 hospitalizations and over 29,000 emergency department visits for a primary diagnosis of diabetes
- Diabetes disproportionately affects certain racial and ethnic groups, the medically underserved, the elderly, and the economically disadvantaged
- The prevalence of diabetes in Maryland adults has continued to rise in recent years

The AHRQ-funded study conducted an extensive review of studies and reports published from 1976 to 1994 on diabetes in minorities. Key findings show:

- With the exception of Alaska Natives, minorities have more frequent occurrence of type 2 diabetes than do Whites
- Improving the lipid (fats in the blood) profile of Blacks could assist in lowering the risks associated with diabetes-related heart disease
- Health care interventions that integrate cultural and population-specific characteristics can reduce the occurrence of diabetes and the resulting complications for people with the disease

Through this analysis, AHRQ identified the following common barriers to treatment for the Hispanic population.

- Distrust of insulin therapy
- Preference for traditional therapies
- Fatalistic acceptance of the course of the disease

To assess the quality of diabetes care provided to Maryland HMO members, MHCC requires that health plans comprehensively measure and report the percentage of adult members diagnosed with diabetes who have received the recommended care within recommended time periods to achieve healthy levels of sugar and fat (LDL) in their blood. In 2007, only 13 percent of diabetics enrolled in Maryland HMOs received all recommended services (blood glucose testing, eye exam, cholesterol screening, monitoring for kidney disease), and showed adequate levels of control for blood pressure, blood sugar, and LDLs.

## ADDRESSING CONSUMER ACCESS TO HEALTH CARE — MARYLAND LAWS AND PROTECTIONS

The State has a key interest in promoting the quality of care given to plan members. The following are some of the assurances, regarding access to care, that HMO consumers have under Maryland law. These are not to be regarded as substitutes for actual law.

**Access to OB/GYN:** A woman may visit her (in-network) OB/GYN or certified nurse midwife for routine care that is medically necessary without first getting a referral from her primary care provider. Insurers and HMOs must allow a pregnant enrollee a standing referral to an obstetrician.

**Access to Specialists:** Insurers/HMOs that do not allow direct access to specialists must, under certain circumstances, allow members to receive a standing referral for a specialist or see a specialist outside the plan's network. A written treatment plan may be required.

**Access to Prescription Drugs:** Under the 1999 Patients' Bill of Rights Act, Maryland HMOs must guarantee their members with pharmacy benefits access to prescription drugs that they need. Members can get a prescription drug or device that is not on the plan's list of preferred drugs when 1) no similar drug or device exists; or 2) when a similar drug or device that is covered by the health plan has been ineffective or could cause harm to the member.

The charts on this page summarize how well plans provided their adult members with important diabetes care services. Bar graphs show plan scores and performance for each area. More stars mean better plan performance.

**Performance**

★★★ Above Average
★★ Average
★ Below Average

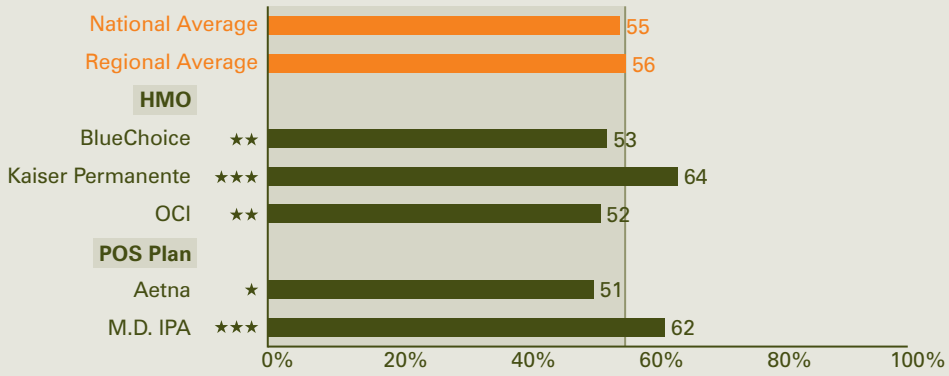
*Stars show "statistically significant" differences between each plan's score and the Maryland average. This means that scores varied by more than could be accounted for by chance.*

**Data Source: Health Plan Records**

## Eye Exams

The percentage of adult members with diabetes who had an eye screening for retinal disease in 2006 (or in 2005, if the retinal exam was normal).

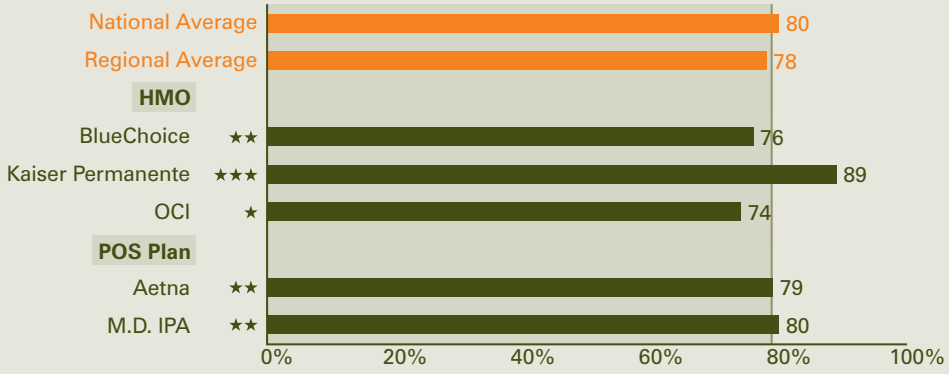
MD Plan Average = 56%
National Average = 55%
Regional Average = 56%




## Medical Attention for Kidney Disease (Diabetic Nephropathy)

The percentage of adult members with diabetes who were checked or treated for kidney disease, known as diabetic nephropathy.

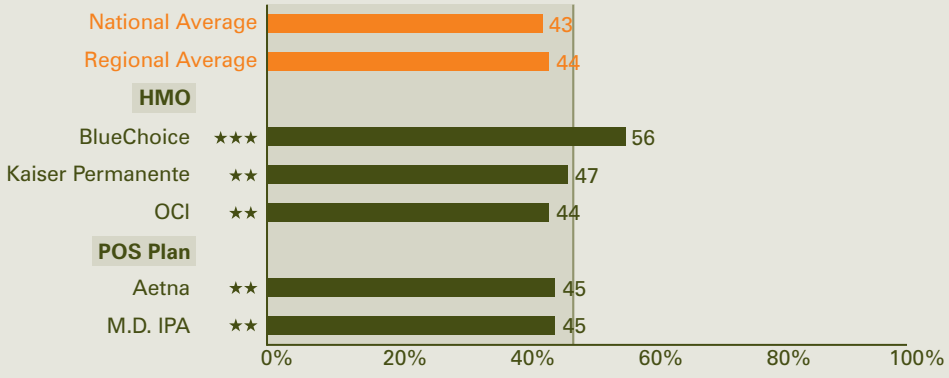
MD Plan Average = 79%
National Average = 80%
Regional Average = 78%




## Cholesterol Control

The percentage of adult members with diabetes whose cholesterol (LDL-C) level was less than 100 mg/dL.

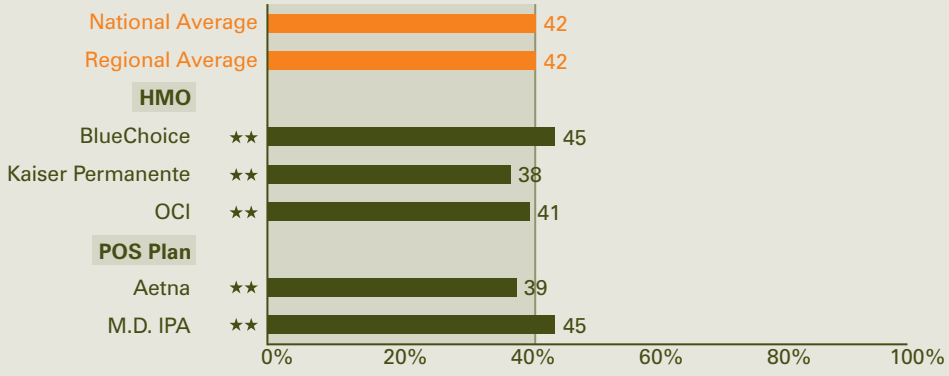
MD Plan Average = 48%
National Average = 43%
Regional Average = 44%




## Good Blood Glucose (Sugar) Control

The percentage of adult members with diabetes whose blood sugar (HbA1c) level is less than 7 percent.

MD Plan Average = 42%
National Average = 42%
Regional Average = 42%



# *Behavioral Health Care*

## ETHNIC/RACIAL DIFFERENCES IN BEHAVIORAL HEALTH CARE

Public policy on behavioral health continues to more effectively mold around the knowledge taken from seminal research. In 2001, the Surgeon General released the report *Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General*. The earlier report summarized the advances in mental health and began a nationally organized effort to remove the stigma of behavioral diagnoses by showing the value of treatment using scientific evidence. This report paved the way to begin probing for possible disparities in this field. The Supplement findings indicated that the available evidence showed that prevalence of mental disorders for racial and ethnic minorities in the United States was similar to that for Whites.

Issues of access to care remain challenging for the entire health care system. Common barriers to care that exist for all persons—whether they seek medical or behavioral health care—include cost, fragmentation of services, and lack of availability of services. Additional barriers deter racial and ethnic minorities from seeking needed behavioral health services: mistrust or fear of the treatment, concerns about discrimination, and communication differences. The 2006 National Healthcare Disparities Report points out that cultural, religious, or social stigma in certain racial and ethnic groups may prevent people in these groups from seeking care for depression and other mental disorders, which makes reducing disparities in this area more challenging than for any other type of care.

Results from the 2005 National Survey on Drug Use and Health (sponsored by the Substance Abuse and Mental Health Services Administration) show an association with race and ethnicity in 2005 among adults experiencing a major episode of depression in the recent year. Asian Americans (3.6 percent) had the lowest rate. Rates for other groups were 9.4 percent among American Indians/Alaska Natives, 7.6 percent among Whites, 7.0 percent among Hispanics, and 6.5 percent among Blacks. Maryland showed an overall prevalence rate of 7.0 percent of adults having a major depressive episode.

## ADDRESSING CONSUMER HEALTH PLAN COMPLAINTS — MARYLAND LAWS AND PROTECTIONS

### Insurance Complaints and Appeals

You have the right to disagree and ask your health plan to change a decision to deny, limit, or not cover a medical service. This is called a "grievance." You can also ask a government agency to decide if the plan's final decision is fair (a "complaint"). The type of plan you have makes a difference in what steps you should take. Ask Employee Benefits or refer to the sections that follow below to learn if your plan is fully-insured or self-insured.

### Fully-Insured Health Plans—State Regulated

Contracts between the State of Maryland and HMOs stipulate that the HMO fully insures all members. The State of Maryland regulates these plans through the Maryland Insurance Administration (MIA); therefore, as a member of BlueChoice, Kaiser Permanente, or OCI you may file a grievance or a complaint after exhausting your plan's internal process*. You can find out more information about filing a grievance by contacting the Consumer Protection Division of the Maryland Attorney General's Office at 1-877-261-8807. To file a complaint, call the MIA at 1-800-492-6116.

### Self-Insured Health Plans—Federally Regulated

The State of Maryland is primarily self-insured for members belonging to POS plans included in this guide and PPOs offered to State employees. Members of these plans must first exhaust their plan's internal process*. A federal law known as ERISA regulates these plans. You may file an appeal to the U.S. Department of Labor (call 1-866-4-USA-DOL) regarding problems that cannot be resolved with your plan or obtain assistance from a mediator from the Consumer Protection Division of the Maryland Attorney General's Office (1-877-261-8807).

**Members of HMO, POS, and PPO plans having a problem that cannot be resolved through the internal process can send their appeal to the Benefits Review Committee. The committee considers appeals on a monthly basis, for which it has received all documentation from the member's provider and plan. Send appeals to: State of Maryland Benefits Review Committee, c/o Employee Benefits Division, 301 W. Preston Street, Rm 510, Baltimore, MD 21201.*

The charts on this page summarize how well plans provided behavioral health services to their members. Bar graphs show plan scores and performance for each area. More stars mean better plan performance.

**Performance**

★★★ Above Average
★★ Average
★ Below Average

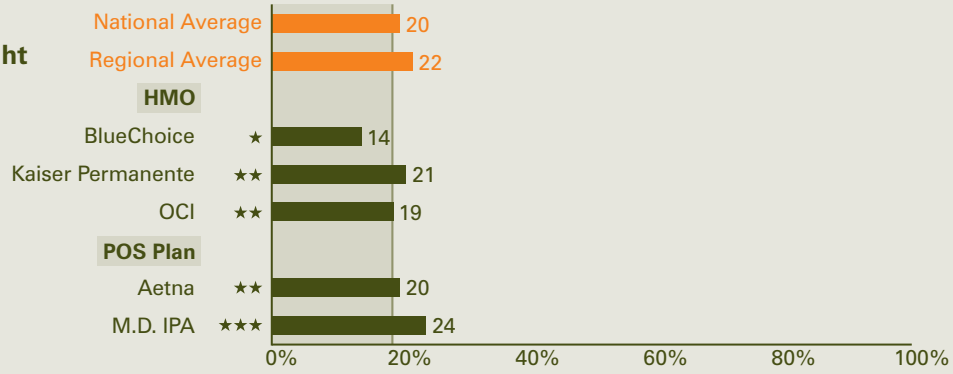
*Stars show "statistically significant" differences between each plan's score and the Maryland average. This means that scores varied by more than could be accounted for by chance.*

**Data Source: Health Plan Records**

## Antidepressant Medication Management—Practitioner Oversight

The percentage of adult members who were treated with antidepressants and who saw a primary care or mental health practitioner at least three times within the first three months of being diagnosed with depression and starting treatment.

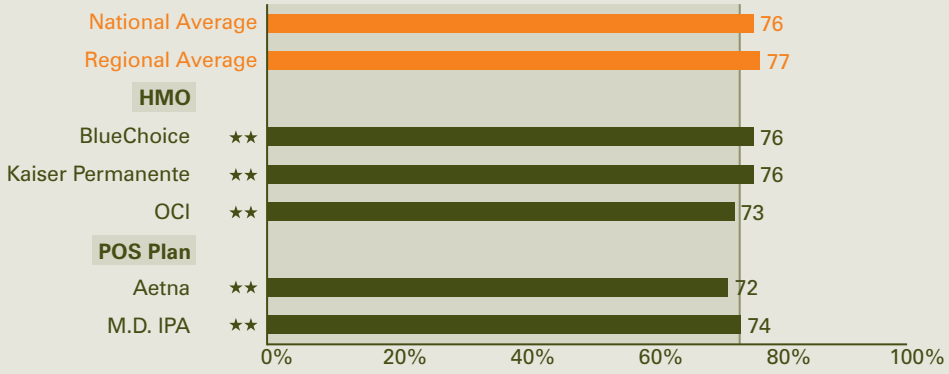
- MD Plan Average = 19%
- National Average = 20%
- Regional Average = 22%




## Follow-Up After Hospitalization for Mental Illness

The percentage of members ages 6 and older who were hospitalized for a mental disorder and were seen at least once by a mental health provider within 30 days of leaving the hospital.

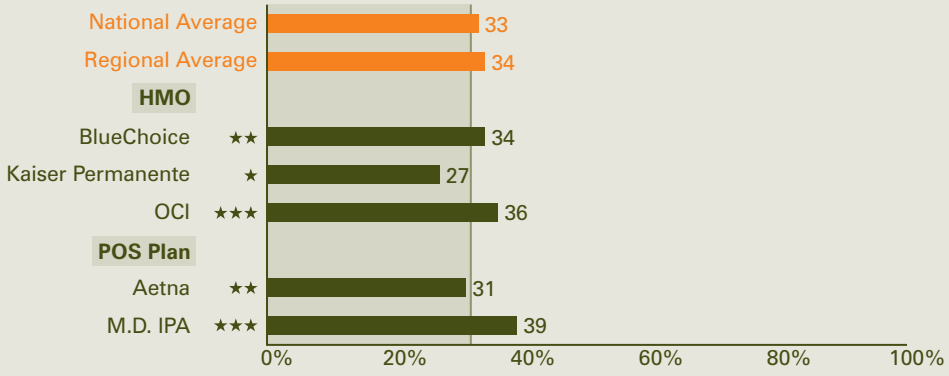
- MD Plan Average = 74%
- National Average = 76%
- Regional Average = 77%




## Initiation of Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder Medication

The percentage of children ages 6–12 given a prescription for ADHD medication, who had one visit with a mental health provider within 30 days of being given the prescription.

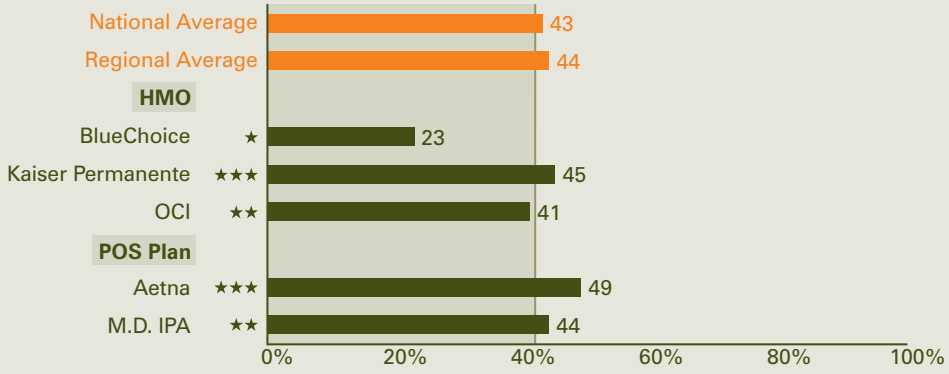
- MD Plan Average = 32%
- National Average = 33%
- Regional Average = 34%




## Initiation of Alcohol and Other Drug Dependence Treatment

The percentage of members ages 13 and older with alcohol and other drug dependence who started treatment through an inpatient admission or outpatient services within 14 days of diagnosis.

- MD Plan Average = 42%
- National Average = 43%
- Regional Average = 44%



## *Comparison to the Region and Nation*

This guide not only compares plans' performance to each other, but also compares their performance as a whole to the region and to the nation. For each measure, the scores of the seven plans required to submit reports to MHCC are averaged to create a 'Maryland Average.' The Maryland average score is then compared to the average score of the region and of the nation.* The table on page 19 presents regional and national averages for all the measures detailed on pages 6-17 of this guide and shows how the Maryland average scores compare to them. Differences are in percentage points.

The regional averages are calculated using 2007 measure rates from 40 commercial HMO/POS plans located in Washington, DC; Delaware; Maryland; New Jersey; Pennsylvania; Virginia; and West Virginia. The national averages are calculated using rates from 274 commercial HMO/POS plans around the country. The source of these averages is the National Committee for Quality Assurance (NCQA), a non-profit organization that compiles and reports quality information. Included in the calculations of the averages are both publicly reporting plans and non-publicly reporting plans (plans that chose not to be identified individually in NCQA's database).

**A t-test was used to determine whether the Maryland average was statistically different from the regional and national averages at the 95 percent confidence level.*

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### SUMMARY OF RESULTS

#### Overall Results by Area of Care

- As in 2006, Maryland's best overall performance was in the Adults' Preventive Care measure category. Maryland plans' average performance was above average compared with the region for all screening measures in this category: Breast Cancer Screening, Screening for Chlamydia, and Screening for Colorectal Cancer. Breast Cancer Screening rates for the state, region, and nation declined between 2005 and 2007; part of this shift may be attributable to changes to the measure's specifications. Maryland also outperformed the nation in two of the three screening measures.
- Maryland did well overall in providing care to patients with diabetes. In 2007, when compared with the region and nation, Maryland performed similarly or above average in all diabetes care measures. Plan records show that, on average, 79 percent of members diagnosed with this disease received medical attention for kidney disease.
- Maryland's performance was above average compared with the nation in child well-care measures. However, the regional rates exceeded both the nation and Maryland in Well-Child Visits for Infants and Children and Well-Care Visits for Adolescents.
- Opportunities for improvement continue to exist in the area of Member Satisfaction. Regionally and nationally, plan members report higher levels of satisfaction with the care and services that they receive compared to the members enrolled in Maryland health plans. It is noteworthy that rates for Getting Needed Care and Getting Care Quickly were affected dramatically by changes in the specifications for these measures. The Maryland average for Getting Needed Care decreased by 31 percentage points between 2005 and 2007, while the average for Getting Care Quickly increased by 12 percentage points.

#### Measure-Specific Results

- In 2007, Maryland had a higher average performance than the region in 5 of 23 measures. It also had a higher performance than the nation in 5 measures. However, for the remaining 18 measures, the region had a higher average performance in 9 measures and the nation had higher performance for 6 measures.
- The table below identifies the measures in which Maryland performed above both the region and nation, as well the measures in which Maryland performed below both the region and nation.

**Table 2: Measures in Which Maryland Performed Above or Below Both Region and Nation**

| Performance Above Both the Nation and Region | Performance Below Both the Nation and Region |
|---|---|
| Chlamydia Screening | Rating of Health Plan |
| Screening for Colorectal Cancer | Getting Needed Care |
| Cholesterol Control | Immunizations for Children |
| | Follow-Up After Hospitalization for Mental Illness |

## Table 3: Comparison of Maryland, Regional, and National Averages

| Measure | Maryland | Region | Difference Between Maryland and Region | Maryland Performance Compared to Region | Nation | Difference Between Maryland and Nation | Maryland Performance Compared to Nation |
|---|---|---|---|---|---|---|---|
| **Member Satisfaction** | | | | | | | |
| Cost of Prescription Drugs | 11% | NA | NA | NA | NA | NA | NA |
| Getting Care Quickly | 56% | 58% | -2 | ★ | 57% | -1 | ★★ |
| Getting Needed Care | 46% | 49% | -3 | ★ | 50% | -4 | ★ |
| Rating of Health Plan | 34% | 37% | -3 | ★ | 38% | -4 | ★ |
| **Adults' Preventive Care** | | | | | | | |
| Screening for Chlamydia | 44% | 36% | 8 | ★★★ | 37% | 7 | ★★★ |
| Screening for Breast Cancer | 69% | 67% | 2 | ★★★ | 69% | 0 | ★★ |
| Screening for Colorectal Cancer | 57% | 55% | 2 | ★★★ | 55% | 2 | ★★★ |
| Check-Ups for New Moms (Postpartum Care) | 78% | 81% | -3 | ★ | 80% | -2 | ★★ |
| **Children's Health** | | | | | | | |
| Appropriate Medicine for Children With Asthma | 95% | 95% | 0 | ★★ | 95% | 0 | ★★ |
| Well-Child Visits for Infants and Children | 76% | 78% | -2 | ★ | 70% | 6 | ★★★ |
| Well-Care Visits for Adolescents | 45% | 47% | -2 | ★ | 40% | 5 | ★★★ |
| Immunizations for Children | 63% | 66% | -3 | ★ | 66% | -3 | ★ |
| **Chronic Care** | | | | | | | |
| DMARD in Rheumatoid Arthritis | 83% | 82% | 1 | ★★ | 85% | -2 | ★ |
| Persistence of Beta-Blocker Treatment After a Heart Attack | 75% | 75% | 0 | ★★ | 73% | 2 | ★★ |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD | 35% | 35% | 0 | ★★ | 36% | -1 | ★★ |
| Controlling High Blood Pressure | 59% | 60% | -1 | ★★ | 60% | -1 | ★★ |
| **Diabetes Care** | | | | | | | |
| Cholestorel Control | 48% | 44% | 4 | ★★★ | 43% | 5 | ★★★ |
| Medical Attention for Kidney Disease (Diabetic Nephropathy) | 79% | 78% | 1 | ★★★ | 80% | -1 | ★★ |
| Good Blood Glucose (Sugar) Control | 42% | 42% | 0 | ★★ | 42% | 0 | ★★ |
| Eye Exams | 56% | 56% | 0 | ★★ | 55% | 1 | ★★ |
| **Behavioral Health Care** | | | | | | | |
| Initiation of Alcohol or Other Drug Treatment | 42% | 44% | -2 | ★★ | 43% | -1 | ★ |
| Initiation of Follow-Up Care for Children Prescribed ADHD Medicine | 32% | 34% | -2 | ★★ | 33% | -1 | ★★ |
| Antidepressant Medication Management—Practitioner Oversight | 19% | 22% | -3 | ★ | 20% | -1 | ★★ |
| Follow-Up After Hospitalization for Mental Illness | 74% | 77% | -3 | ★ | 76% | -2 | ★ |

**LEGEND**

★★★ = Maryland HMO/POS average is above the regional/national average by a statistically significant margin
★★ = Maryland HMO/POS average is statistically equal to the regional/national average
★ = Maryland HMO/POS average is below the regional/national average by a statistically significant margin
NA = Data collected by Maryland; similar data not available regionally or nationally

# *Measuring Health Care Disparities*

## DISTINGUISHING BETWEEN HEALTH DISPARITY AND HEALTH CARE DISPARITY

Endeavoring to identify where substantive differences in the health-health care relationship are rooted carries the obligation of defining how these aspects differ. The 2003 *National Healthcare Disparities Report* (NHDR) noted the lack of consensus on the definition of disparity. "Disparity" in health outcomes, health status, and health care has been defined in several ways. In terms of health outcomes and treatment, it is important to make a distinction between a health disparity and health care disparity; health disparity deals with health outcomes and illness burden, while health care disparity is related to conditions of access, treatment, and quality. Health plan quality measurement will focus on the latter in its evolving efforts to elevate quality.

## NATIONAL DISPARITIES MONITORING

A host of public and private undertakings are attempting to redesign the health care system to one more suitable to Americans' lifestyles, sensibilities, and economic capacity for optimization. Mobilizing legislation and studies of health care disparities have taken defined steps to learn where the health care system has viable opportunities to ensure equitable opportunity for quality health care services for everyone. In 1999, Congress mandated that AHRQ produce an annual report on health care disparities in the United States (Public Law 106-129). The *National Healthcare Disparities Report,* first released in 2003, includes a broad set of performance measures used to monitor progress toward improved health care quality for all Americans. Building on the 2002 Institute of Medicine (IOM) report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare,* which demonstrated that racial and ethnic disparities in health care exist, the NHDR provides a comprehensive view of the scope and characteristics of differences in health care quality and access associated with patient race, ethnicity, language, culture, income, education, insurance coverage, and place of residence. NHDR measures assess clinical performance, patient opinions, and outcomes.

The NHDR aims to help policymakers and researchers determine the areas of greatest need, monitor trends over time, and identify programs that will succeed in addressing disparities. Four key themes were highlighted from findings in the 2006 NHDR.

1. Disparities are still prevalent
2. Some disparities are decreasing, while others are increasing
3. Opportunities for reducing disparities remain
4. Information about disparities is getting better, but gaps still remain

## MARYLAND PLAN TO ELIMINATE MINORITY HEALTH DISPARITIES

The 2006 *Maryland Plan to Eliminate Minority Health Disparities,* developed by the Office of Minority Health, Department of Health and Mental Hygiene, is offered as a beginning dialogue on the causes, solutions, and challenges faced by the State. The purpose of this plan is to provide information to help Maryland's communities plan and implement ways to reduce minority health disparities by documenting disparities in prevalence and quality of health care, monitoring trends, and identifying areas for improvement. To assist policymakers and researchers in determining solutions to reduce disparities, this plan recognizes and directs systematic collection of complete, accurate data on health and health care for the targeted racial and ethnic groups. Systematic collection of data will provide the baseline and regular monitoring needed to assess changes in disparities.

Effective October 1, 2007, a new law permits Maryland health plans to collect race and ethnicity information at the time of application for health insurance. This information will allow health plans to evaluate the quality of care provided to members and to assess outcomes using available racial and ethnic information. As more becomes known about members' race and ethnicity, health plans may have a new opportunity to address disparities and improve their health care.

## EVALUATING RACIAL DISPARITIES USING HEDIS MEASURES

Tracking rates of care using quality measurement tools such as HEDIS enables managed care plans and policymakers to identify areas susceptible to improvement. In particular, managed care plans have the potential to influence the quality of care their members receive by developing supportive systems that optimize the health care experience. As a measurement tool, HEDIS has been useful in quantifying the delivery of evidenced-based or consensus-based care that plan members receive. Although this tool primarily emphasizes collection of process measures that evaluate how often recommended tests or procedures occur, it does include several intermediate outcome measures. Focus on the process of care stems from the availability of claims data, validity across populations, and permissibility of computing rates without further adjustments for other factors.

Maryland has used HEDIS to collect and report on the performance of commercial HMOs operating within the State since 1997; however, barriers to collecting race, ethnicity, and other individual characteristics have prevented penetration into sub-populations using HEDIS data to identify gaps in quality. With the passage of new Maryland legislation, health plans now have the authority and opportunity to begin more comprehensive collection of members' race and ethnicity, thus eroding some of the information gaps necessary to conduct population-specific quality analysis and development of targeted quality improvement programs. Maryland's experience does not reflect a detachment from what has happened nationally. National studies reveal that prior to 2003 very few organizations used data-driven initiatives to reduce disparities in the quality of health care. The proficiency of HEDIS as a health care disparities measurement tool will become better understood as characteristics of health plans' members become integrated into the measurement process.

Some disparity information is already known. Using Medicare files to obtain beneficiary demographics combined with HEDIS data to obtain information on those enrolled in the government-sponsored managed care plans, research findings show that Blacks and Whites experience differences in the rates of care for process measures such as Breast Cancer Screening, Diabetic Retinal Eye Exams, and Use of Beta-Blockers After a Heart Attack. However, those differences have diminished over time. Intermediate outcome rates reflect a more intractable nature, with rate differences persisting.

The research work done to date provides several key points.

- Plan-specific performance reports of racial disparities on outcome measures would provide useful information not currently conveyed by standard HEDIS reports.
- Risk adjustments may be necessary to assure valid inferences about quality.
- HEDIS protocols do not account for individual provider practices, patient attitudes about health, or patient ability to modify unhealthy behaviors.

## *Maryland Performance Reports*

For additional information on health plan quality and performance, visit the MHCC Web site at **http://mhcc.maryland.gov/consumerinfo/**.

- *Measuring the Quality of Maryland HMOs and POS Plans: 2007/2008 Performance Report.* Contains information similar to this guide, but covers all seven HMO and POS plans reporting their quality information to the State of Maryland.
- *Comprehensive Performance Report: Commercial HMOs & Their POS Plans in Maryland.* Contains more plan-specific rates on HEDIS (clinical) and CAHPS (survey) measures.

For information on the performance of health care facilities, visit the MHCC Web site to view these three Web-based, interactive guides.

- *Maryland Hospital Performance Evaluation Guide.* Compares the quality of care provided by Maryland hospitals.
- *Maryland Nursing Home Performance Evaluation Guide.* Compares comprehensive nursing care facilities and continuing care retirement communities in Maryland on age or functional ability of residents and on measures of quality.
- *Maryland Ambulatory Surgery Facility Consumer Guide.* Compares descriptive information about ambulatory surgery facilities and their services.

# *Important Information About Dependent Child Age Expansion*

Effective July 1, 2008, dependent unmarried children of a State employee or retiree, who are also the employee/retiree's tax qualified dependent, will be able to be covered on the employee's or retiree's benefits coverage through the end of the month in which they reach age 25. This change is effective July 1, 2008 (not January 1, 2008) because the State health benefit plan contracts run on a fiscal year basis and renew on July 1 of each year.

Effective July 1, 2008, full-time student status or disability status will no longer be needed to cover unmarried dependent children who are tax qualified dependents until age 25. Disabled unmarried dependent children will be allowed to continue on the coverage beyond the month in which the child turns age 25, if the child is certified as permanently disabled. A Disability Certification Form will be available on The Department of Budget and Management's Web site or directly from your medical plan.

Until July 1, 2008, an unmarried dependent child can remain on your coverage through the end of the year in which they turn age 19. Beyond the end of the year in which they turn age 19, they can remain on your coverage if they are certified as a full-time student or certified as disabled, until the end of the year they reach age 23 or lose full-time student status or disability status, whichever occurs first. Currently, disabled children can remain on your coverage beyond age 23 if they continue to be certified as disabled.

If you have a dependent unmarried child who will be eligible after July 1, 2008, but is currently not on your coverage, you will be allowed to enroll your child during the upcoming spring 2008 Open Enrollment for an effective date of July 1. **Please read the Open Enrollment material you received in the spring for enrollment instructions and more detailed information regarding eligibility.**

# *Plan Service Areas and Contact Information*

| Health Plan | Maryland and Adjacent Services Areas (Maryland Jurisdictions Within Each Region Are Listed Below) | | | | | Customer Service Information |
|---|---|---|---|---|---|---|
| | Baltimore Metro Area | Washington, DC Metro Area | Eastern Shore | Southern Maryland | Western Maryland | |
| **HMO** | | | | | | |
| **Carefirst BlueChoice, Inc. (BlueChoice)[a]** | ✔ | ✔ | ✔ | ✔ | ✔ | 866-520-6099<br>7:00 am-7:00 pm<br>Monday–Friday<br>8:00 am-1:00 pm<br>Saturday<br>**www.carefirst.com** |
| | Northern Virginia | | | | | |
| **Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Permanente)[b]** | ✔ | ✔ | NA | ✔ | ✔ | 800-777-7902<br>301-468-6000<br>For the hearing and speech impaired:<br>301-879-6380<br>7:30 am-5:30 pm<br>Monday-Friday<br>**www.kaiser permanente.org** |
| | Northern Virginia | | | | | |
| **Optimum Choice, Inc. (OCI)[c]** | ✔ | ✔ | ✔ | ✔ | ✔ | 800-709-7604<br>24 Hours, 7 Days<br>**www.mamsiUnited Healthcare.com** |
| | Washington, DC; Virginia; Delaware; West Virginia | | | | | |
| **POS Plan** | | | | | | |
| **Aetna Health Inc.—Maryland, DC and Virginia (Aetna)** | ✔ | ✔ | ✔ | ✔ | ✔ | 800-323-9930<br>8:00 am-6:00 pm<br>Monday-Friday<br>**www.aetna.com** |
| | Northern Virginia, Richmond, Roanoke, Hampton Roads | | | | | |
| **MD-Individual Practice Association, Inc. (M.D. IPA)[c]** | ✔ | ✔ | ✔ | ✔ | ✔ | 800-709-7604<br>24 Hours, 7 Days<br>**www.mamsiUnited Healthcare.com** |
| | Washington, DC; Virginia | | | | | |

[a] BlueChoice, a for-profit HMO, operates under a holding company called CareFirst.
[b] Kaiser Permanente's performance in this guide relates to HMO members only. It is the only non-profit HMO operating in Maryland.
[c] Two for-profit HMOs, M.D. IPA and OCI, are owned and operated by Mid-Atlantic Medical Services, LLC (MAMSI), a regional holding company and subsidiary of UnitedHealth Group, Inc.

## REGIONS

**Baltimore Metropolitan Area:** Baltimore City, Baltimore, Carroll, Harford, Howard, Anne Arundel
**Washington, DC, Metropolitan Area:** Montgomery, Prince George's
**Eastern Shore:** Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, Worcester
**Southern Maryland:** Calvert, Charles, St. Mary's Western Maryland: Allegany, Frederick, Garrett, Washington

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